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ABSTRACT

This report on a Comprehensive Community Child Care (4C) pilot project to train family day care providers describes the step-by-step procedures for setting up, operation and assessment of the program. The program was conducted primarily through home visits and group meetings, with extensive use of handout materials. Sixty voluntary participants, all welfare department certified providers, were trained in two groups, in succeeding sessions (11 and 14 weeks). Experiences of the first group resulted in some changes in planning for the second session. The report's first section describes recruitment and organization of the interdisciplinary training staff. The second section is devoted to the program itself, beginning with provider recruitment and the geographical matching of providers and trainers (20 to 2 in the first group and 40 to 3 in the second group). The weekly one-hour home visits emphasized child participation. The group meetings, eight per session, with topics chosen by providers, involved occasional outside speakers. Identification of community resources included development of a directory of providers and a community resource sheet, as well as use of outside materials and field trips, with emphasis on library use. A family day care association was formed as a mutual support network to deal with areas such as insurance, tax deductions, clothing exchange, toy safety and information on child development. The report's final section notes the need for continuity and followup between the home-visit and group-meeting components and includes descriptions of program documentation and an assessment of changes in pre- and post-program provider questionnaire responses. (BF)

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PREFACE

We did not plan to write this report. We had not expected to print a report. It evolved.

Evolve. That word characterizes the pilot training/orientation project we conducted for family day care home providers. As we came to the last week of the pilot and prepared to write a final report to our funding agent, an idea occurred to us.

As we reflected over the past five months, we became aware of how many processes and procedures we had developed. Therefore, instead of describing these in a personal style solely for an "in-house" report, we chose to write in a more general form and share our birth pangs with a wider audience.

We are aware of the lack of procedural reports in the family day care field. Our hope is that this primer, this beginning, will be useful to other staff as programs are initiated.

Whereas many family day care programs focus on the service offered to the provider for her children in the home, our pilot emphasized orienting the provider to resources, both human and material, in her community. Those resources to which frequent mention is made throughout the report include:

4C = Comprehensive Community Child Care,
HCWD = Hamilton County Welfare Department,
DCU = Day Care Unit (at HCWD) and,
DCCDCA = Day Care and Child Development Council of America.

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1.1 RELATIONSHIP BETWEEN WELFARE DEPARTMENT, 4C, PROVIDERS

The relationship between the Hamilton County Welfare Department (HCWD), Comprehensive Community Child Care (4C), a non-profit organization, and the family day care providers was both professional and personal.

Under P.L. 94-401 supplemental funds to Title XX, 4C submitted a proposal to the Hamilton County Welfare Department to train/orient sixty family day care providers. It was a pilot project in that no weekly, regular service had been offered to providers anywhere in Hamilton County in the comprehensive manner which was proposed. In essence, HCWD contracted with 4C to give this service to a sample of their providers. All HCWD providers have been certified by staff of their Day Care Unit.

The proposal from 4C was submitted in September, 1976 and a budget was finally approved in April, 1977 to allow the pilot to start. Once funding was approved, Home Care Staff from 4C were given the names of HCWD certified providers who had indicated an interest in training. Participation in the program was purely voluntary for the providers. After HCWD Day Care Unit staff gave 4C providers' names, their major responsibility to the project staff ended.

After receiving the names of certified providers interested in training/orientation, 4C Home Care Staff recruited them into the pilot program. The proposed total of sixty providers was divided into two sessions: session I had twenty providers and session II had forty providers.

Professionally, there was good communication and cooperation between HCWD and 4C as was evident by the following:

1) a jointly sponsored workshop with Bob Bookman of the DCCDCA
2) Day Care Unit Staff attendance at 4C Home Care-sponsored provider group meetings and,
3) Day Care unit staff participation in a Recognition Dinner at which certificates were given to each provider.

Personally, the Day Care Unit Staff was most supportive to 4C Staff and they volunteered to assist whenever asked. The Day Care Unit Staff far exceeded normal agency to agency relationships. A very keen, regular interest was shown by staff as "their" providers became active in the training/orientation project.

1.2 GOALS OF THE TRAINING/ORIENTATION

As the pilot project with family day care providers began, our thrust in working with them was to help orient them to each other and to their community. The word "train" had some negative implications in that professionals from outside the home could presume to come to a home and teach a provider. It seemed to imply a one way direction of communication. We felt that if, from the start, we as staff thought of "orienting" providers, then we were offering opportunities.

Some of the objectives we used to carry out our orientation pilot were as follows:

1) to assist and support the provider as she cared for children in her home,
2) to establish linkages for providers with resources in their community,
3) to initiate a system for providers to identify each other as resources, and
4) to give recognition to providers as a profession.

1.3 HIRING STAFF

The timing when funds became available for this new service was critical in terms of hiring staff. In our case, there was approximately one and one half weeks between notification that the project had an approved bank account from which salaries and supplies could be drawn, to the date when staff should have begun giving service to the providers.

Job openings had to be advertised; resumes needed to be screened and personal interviews had to be arranged. Initial interviews were conducted by project staff followed by a final interview which included the 4C Board Chairperson and Executive Director. Due to shortness of time, all screening and final interviews were completed within a week.

At this stage we encountered a problem. Most of the applicants held current jobs elsewhere. Since applicants owed their present employer a courtesy two week resignation period, when they were able to join the project it was necessary that the new staff begin to work with providers immediately. The significance of this time lag for the project was that the anticipated orientation period for staff never materialized.

As with almost any pilot program or project, the staff hired are definitely a key component. The project budget will determine, to some extent, the level of experience and skill of a person who can be hired, the job description and duties will suggest the particular qualities needed. Fortunately, this pilot had a budget which planned for hiring "professional" trainers. It was fortunate because, with no time whatever for orientation, it was essential that newly hired staff could walk into the job and begin to relate appropriately with providers. Based on our experience we are recommending that careful consideration be given to the amount of time allowed for pre or in-service training. If project time allows for little or no training, then a good match would be hiring "professionals". However, if sufficient time is available, entry level staff positions might be considered, including current providers.

1.4 INTERDISCIPLINARY STAFF

One of the decisions to be made before hiring begins is the area of discipline or field of formal training required of the applicants. Based on our successful experience, we recommend an interdisciplinary staff. Our pilot hired a Registered Nurse and a former Welfare Department Social Caseworker. We felt that these two backgrounds, in addition to Child Development complimented each other well and expanded the service we were able to offer the providers.

In all fairness, it should be admitted that our original proposal did not include job descriptions for staff in areas other than Child Development. Our interdisciplinary staff was not planned, it was the result of happenstance. The project, due to late funding, started in April, too early to attract the June graduate. As a consequence, job inquiries were few and applicants, who by their professional background might not normally be considered, were given the opportunity to interview.

At this point we hasten to say, lest there be any misunderstanding, that "interdisciplinary" may well mean a combination of staff, that is, several staff from more than one discipline or several staff with years of experience in more than one area but without a paper degree. It seems to us that one of the benefits of family day care is that a system for it is so relatively new that there is little precedent for how it "should be done".

The opportunity is now present for forward thinkers to hire staff who have demonstrated needed abilities or skills. Family day care providers can be very frank people; they can quickly strip away a veneer. They are not accustomed to being interrupted from their important job of caring for children. Therefore, the staff with whom they relate in a program need to be both sure of their area and able to relate to providers. To find people who possess these two qualities poses an exciting hiring challenge.

1.5 STAFF ORIENTATION

Each staff has its own style, its own personality, its own stage of development. Ours was a pilot project with an interdisciplinary approach. Among us we shared the experience of a Registered Nurse, a Social Caseworker, a Child Development Specialist, a college work-study researcher and a project secretary. Each of these individuals joined the staff at a different time. The Project Coordinator began full-time in mid April and by the end of June the work-study student began working with us as the last staff person to come "on board".

As has already been mentioned, due to lateness of funding, no time was available in which to have a separate, formal staff orientation. The Project Secretary began work almost as soon as she was hired. One of the trainers needed to give a two week termination notice to her previous employer. When she arrived for her first day of work, we started out that day to make visits to providers and what staff orientation there was, occurred in the car in brief conversations between home visits. Our program epitomized the phrase "on the job training".

The basic components from which we began were the following:

1) This was a pilot training/orientation project;
2) No large scale support system for family day care providers had previously existed anywhere in the greater metropolitan area;
3) None of the staff had had any direct experience working with providers; and,
4) Because of the interdisciplinary background of the staff, neither the coordinator nor the trainers had experienced a close working relationship with each other's fields.

What we shared in common was that first, all of the trainers were mothers with young children of their own; second, we all had a genuine respect and concern for other human beings; third, all of us were intrigued and challenged to be involved in a new system of delivery of service. It was our interest in seeing that the project succeeded which provided the common link and enabled three very distinct personalities to work together as a team.

For this project, staff orientation was definitely more a mutual sharing and discussion of ideas than a formal orientation directed by one person. We had the benefit of three diverse perspectives to find solutions to problems as they arose. Because of time limitations, only a brief period of joint discussion was possible before all of us needed to implement a new policy; we interpreted it to providers in our own style and somehow the message was consistent.

1.6 STAFF MEETINGS/CONFERENCES

Many styles of organization are successful. Here, we are simply sharing our own style. It seemed to work for us. Other styles might have been an improvement. However, what we believe all staff strive toward, regardless of their style, is open communication.

As an earlier reference indicated, our staff joined the project over a two-month time period. Initially, Trainer I and the Coordinator had staff-type discussions while driving in the same car to make the first home visits. As we completed that introductory stage and paired off to visit providers separately, our meeting evolved into a more formal arrangement.

Friday seemed to be a good day for holding individual staff conferences. It was a good time to sum up the week past and plan for the week to come. The conferences were used for both project related information as well as an emotional sharing of feelings.

The conferences were scheduled in the Community Chest cafeteria. Holding the staff conference in a room such as the cafeteria had several advantages:

1) it was close to the food and one could easily buy a cup of coffee, juice or a roll and this contributed to a relaxed atmosphere
2) it was a change from our desks--we could see a different perspective and,

3) it was private. In the large 4C office with staff at desks so close together they touched, it was important to be able to regularly leave a cramped space.

The philosophy behind having regular, weekly conferences with so few staff was an acknowledgement that the size would grow and problems do arise. Rather than suddenly needing to make new meeting arrangements when a crisis occurred, it seemed sensible to establish a precedent for these private conferences from the start. These individual conferences were held with each staff person including the Secretary. This was a very helpful process which kept the Coordinator informed of staff ideas and morale. The Project Secretary was often the only home care staff person in the office, and it was important for her to be able to regularly comment on the overall flow of work and general office atmosphere.

We began holding informational and decision-making staff meetings on Monday mornings after all staff had joined the project. Because of the load of regular home visiting plus preparing for session II recruitment, this Monday morning meeting was sometimes our only time together as a staff throughout the entire week.

The project operated with these two types of regular weekly meetings for approximately one and one-half months. As we moved into session II, we more easily anticipated and planned ahead. We had time to discuss and organize a variety of small jobs and assign tasks on a monthly basis.

Now, at project end, it appears that two opportunities a week in which staff knew they could voice their opinion and be heard was a healthy safety valve. One cannot assume that working in close physical proximity means that all is well. It is important to keep the lines of communication open.

2.1 RECRUITMENT: WHAT IS INVOLVED

The population of the 4C Home Day Care Orientation Project was providers certified by the HCWD Day Care Unit. This group was selected because they were the only "visible, identified providers" in Hamilton County.

SESSION I

The criteria used in the selection of providers was as follows:

1) general providers were selected, as opposed to "client-related" providers chosen to be certified by a parent;
2) providers had at least 6 months experience as a provider;
3) providers had good feelings about themselves; and
4) providers had requested some type of training.

A fifth criterion, geographic location, was added later.

The process and the time for recruitment had not been scheduled, by oversight and by lack of experience. Because the certified providers' names were to come from Hamilton County Welfare Department (HCWD), time for recruitment had not been designated in the proposal. In reality, Day Care Unit (DCU) staff had to complete several very important steps before the Project Coordinator could begin her part of recruitment. DCU Staff pulled the files of providers who had indicated an interest in training, compiled a list of these providers' names, telephone numbers and addresses, and, in some cases, called providers to assure them that HCWD approved of the training project which they would shortly be hearing about from 4C.

The list of interested providers was given to the 4C Home Care Project Coordinator who then began the actual recruitment telephone calls. At this stage, the rest of the Home Care Staff had been hired but none had joined the project yet. The Coordinator decided to limit the calls, to providers in selected zip codes, to economize on driving time.

To summarize recruitment, the Coordinator called providers, described the new program and made appointments with them for an initial visit. Thus several days of the Coordinator's time, plus the additional uncounted time of the Day Care Unit Staff, was used to enroll twenty providers into a new program.

SESSION II

The process for recruiting participants in session II involved four areas. First, staff met and evaluated the recruitment process used in session I and decided to make changes to expedite the process. Since most of the providers who had requested training from HCWD had been contacted for session I, it was felt that new criteria were needed for session II. Therefore, the criteria for session II participants were as follows:

1) Multi-family providers--those providers certified to care for children from more than one family were a priority;
2) the provider had at least 6 months experience as a provider;
3) the provider was currently caring for at least one child; and
4) the providers lived in a limited geographic area.

However, as the process began, it became apparent that the criteria were unrealistic. By the end of the recruitment for session II the only criterion that remained was the necessity to have a current placement.

Lists of certified providers were again obtained from HCWD by 4C Home Care Staff. The recruitment which began the first week of July announced that session II would begin July 18. Our goal was to recruit forty providers from a relatively small geographic area. Trying to concentrate on certain parts of the city, we compiled a list with zones and neighborhoods corresponding to providers' names. The first list contained forty-six names.

A staff person began calling the providers by telephone. Each call involved introducing the caller, 4C, and an explanation of the program. Special emphasis was put on the providers' required attendance at a minimum of six evening group meetings out of the scheduled eight. Along with this, the staff caller explained that transportation and babysitting services would be available. She talked about the providers' personal benefits from the program and named some specific topics. It was stated that providers would receive a stipend for their participation, but the actual amount was never disclosed. The same narration was presented to each provider called.

In those cases where providers indicated an interest, in being included in the training project, the staff person then arranged for an initial visit to their home. These appointments were arranged at the providers' convenience and according to the three trainers' schedules.

As mentioned previously, the first list included the names of forty-six providers who were potential participants in the program. As the calling continued, the number of available names quickly diminished. Some were on vacation or not home; others were clearly not interested in training. Every provider was repeatedly called until actual contact was made. Finally, the total list of providers contacted included over 150 names. From this list, approximately every third person was interested in training and scheduled an appointment. It took telephone contact with 150 providers to obtain a final enrollment of forty-three.

Although five to ten initial visits were scheduled per day, several providers cancelled their appointments and often these cancellations were not called to the 4C office; rather, they occurred after the trainer had already left the office.

Our recruitment time was very limited in that we were simultaneously completing session I training and had not allowed a turn-around week between sessions. Unexpected cancellations hindered us even more. It became apparent, because of recruitment lags and the enormous amount of paper work and organization needed between sessions, that the beginning of session II would have to be postponed until the last week of July. With this additional week, we were able to finish the phone calling, which took approximately seven days and completed the initial home visits to providers' homes, arriving at a final enrollment of forty-three.

2.2 STIPENDS: WHAT IS THEIR EFFECT

SESSION I

The fact that a stipend would be paid to providers enrolled in the training was not mentioned to providers on the initial recruiting calls. About five weeks into the session the stipend was mentioned but an exact amount was never cited and none of the providers asked about the specific amount.

No criteria was stated for receipt of the stipend; therefore, it could not be used for leverage to encourage provider participation. Staff discussed this issue at length, and eventually determined that stipends could not be withheld because of limited participation. Since these stipulations had not been stated to the providers originally as a condition for the stipend, it was decided that all providers would receive $110 at the end of the session regardless of the number of home visits or group meetings attended. The three providers who had voluntarily given regular transportation to other providers received a separate small sum in addition to the stipend.

SESSION II

Prior to the start of recruiting for session II, staff discussed the criteria to be used for receipt of the stipend. Since attendance at group meetings had been a far greater problem in session I than missed home visits, the ultimate decision was that payment be based on provider attendance at a minimum of six of the eight session II group meetings. This would necessitate payment at the end of the session as opposed to weekly or bi-weekly payments. This attendance policy was clearly emphasized to providers during both the initial phone call and home visit so no misunderstandings could occur later.

After the first group meeting at which attendance was rather low, staff met again on the issue of the stipend. As a result of that meeting, a letter was sent to each of the providers reminding them of their verbal contractual commitment to attend six meetings. Attendance vastly improved beginning with the next group meeting and none of the providers enrolled missed more than two of the eight meetings.

2.3 STAFF-PROVIDER MATCH UP

The most expedient method to assign providers to trainers was geographic location.

SESSION I

At the beginning of session I, there were twenty providers and two staff members. Both the Coordinator and Trainer I were assigned ten providers covering a relatively small geographic area. This provider-trainer match up was maintained throughout the session. When Trainer II joined the staff, midway through the session, she worked with the four providers who had been added late in the training session to replace early dropouts.

SESSION II

Trainers were again matched with providers according to geographic areas. A map was drawn to show where the newly recruited providers lived and on the basis of this information, each provider was assigned to a single, specific trainer. Since we were covering a far larger territory than in session I, trainers were now working with unequal numbers of providers. The Project Coordinator, who had other time consuming project responsibilities, worked with ten providers; Trainer I who covered the largest geographic area, worked with twelve providers, and Trainer II, in the smallest geographic area, worked with fifteen providers. Again, each trainer visited the same providers throughout the session.

2.4 ASSESSMENT AND TOPIC SELECTION

The initial assessment in both sessions was composed of an "Original Questionnaire to Providers" (see Appendix A) plus their ranking of "Suggested Training Topics" (see Appendix B). The original questionnaire established a baseline of the providers' previous experience and helped to determine provider needs.

The method used for choosing orientation topics in both sessions was to offer providers a variety of topics to rank according to their interest. Space was allotted on the topic sheet for providers to suggest additional topics not already listed. After each provider had ranked the topics, the results were tabulated and the highest ranking topics became the topics for our weekly group meetings. Selected questions from the original questionnaire were asked at the end of each session and change between pre and post assessment was tabulated and analyzed.

SESSION I

As session I progressed, it was noted by staff that certain topic areas had not been covered on the original questionnaire. To obtain new information from providers we designed additional, short questionnaires. What we did not take into account at the time was that these added questionnaires complicated the final tabulation of information from these providers. Further, it was difficult to elicit specific answers to some parts of the questionnaire because the assessment tool was too general. For these questions it was hard to document changes between the pre and post assessment.

SESSION II

By session II, the questionnaire had been re-written to include all areas of information which staff desired to obtain from providers. The method used for topic selection was identical to session I; however, it was pre-determined by staff that a "core" group of topics, on child abuse/neglect, child development, and health and safety, would be included in the orientation.

As in session I, the final assessment was based on selected questions from the original questionnaire and the comparison was completed and analyzed between pre and post assessments. Again the general nature of a few portions of the questionnaire made significant change difficult to document. In

retrospect, during the turn-around time between sessions, the "Original Questionnaire to Providers" should have been revised. At the time however, we were glad just to have our recruitment completed.

2.5 PREPARATION OF HANDOUT MATERIALS

SESSION I

No handout materials had been gathered prior to the beginning of session I due to the providers selection process of orientation topics. It was only after providers had ranked the "Suggested Training Topics" and staff had tabulated the responses, that handouts were compiled.

Resource information was ordered as early as possible,but most did not arrive until late in session I. It was, therefore, necessary to create our own handout materials. The Project Coordinator assigned topics between herself and Trainer I and it was the responsibility of each to research and collect or create appropriate handout materials to cover their assigned topics.

A staff meeting was held each Monday morning during which time the week's materials were organized and discussed and an assignment was made as to which staff person would prepare the materials for the following week's home visit topic. Generally the task rotated between the two staff persons.

As the commercially ordered materials arrived, they were disseminated to providers but not necessarily at the most appropriate home visit. This caused session I to suffer from a sense of disorganization and some lack of continuity.

SESSION II

By session II, most handout materials were on file in the office. This took pressure off staff and resulted in better organization and continuity of materials. Several new handouts were added and some changes were made, but the availability of the "core" materials facilitated the staff preparation for home visits.

Trainer I and II were each responsible for one month for organizing the weekly handout materials in the office. This freed up some time for other staff and assured that providers would receive identical materials each week. A cumulative list was prepared stating each week's handout materials. This masterlist was a quick reference for staff to use to ensure that each provider had received all handout material.

2.6 ESTABLISHING A SYSTEM FOR DAY CARE HOME PROVIDERS TO IDENTIFY EACH OTHER AS RESOURCES

To establish a system for day care home providers to identify each other as resources was one of the primary goals in both sessions of the project. One of the first home visit handouts to the providers was a "Provider Directory" that contained names, addresses and telephone numbers. The list was purposely arranged by neighborhoods rather than alphabetically, to encourage providers to seek out other providers living close to them.

At group meetings, the program was arranged with socializing periods before and after the presentation and providers were encouraged to move about the room and become acquainted with other providers.

SESSION I

In session I, none of the twenty providers enrolled recognized by name any of the other providers in the group. This was somewhat startling to staff in that some of these providers lived in very close proximity to others in the group. As the weekly meetings progressed, several providers discovered that others in the group belonged to their church, or they had some prior contact. None had known each other as "fellow providers".

Except for the four providers who could drive, most providers were given rides to meetings by staff. After several meetings those providers who drove began offering rides home to other providers; and then all providers were receiving transportation services by the last meeting. Many friendships were made and by the end of the session, providers were making arrangements with each other to go on outings independent of project sponsored activities.

SESSION II

Similarly, in session II providers read over the "Provider Directory" and recognized none of the names. However, at the first group meeting, some providers immediately recognized and sought out fellow bingo players or church members. Link-ups seemed to occur more rapidly in session II based predominantly on transportation needs. Providers were aware of the necessity of their attendance at group meetings and it was a matter of expediency to become acquainted with the other providers in their neighborhood in order to travel together to meetings.

Besides socializing at the group meetings, staff also attempted to arrange a neighborhood field trip so that as many of the providers as possible from the same neighborhood could attend the outing together. The neighborhood library was the site of the field trip.

2.7 COMMUNITY RESOURCES

Another goal of the orientation pilot was to assist providers to become more aware of, and better use, resources in their own community. The isolation of providers which we had only read about before the project began was confirmed as truth when we made an initial visit into homes and talked with providers. Once again, because the training staff all had young children, we understood very well the importance of everyone getting out of the house. For several providers who had toddlers and no transportation, our offer to be an extra adult to accompany them, plus drive, was a very well received treat.

SESSION I - FIELD TRIPS

We scheduled field trips to the branch library closest to providers or, if they were already familiar with that resource, we visited the Natural History Museum. Our purpose in going to the library was to assist the providers to apply for a library card, familiarize them with what the library services were and encourage them to borrow books for the day care

children and themselves. The library field trip was a follow-up to one of our first home visits in which the trainers took library books into the home and discussed and/or read them with the provider and children.

A second field trip was arranged to a neighborhood day care center. Our reasons for offering this opportunity were several:

1) to help the home providers become acquainted with another child care service close by, one to which they could turn for activity suggestions,
2) to help the providers observe a group of children, the age of their home day care children, so they could see that the behavior of each was similar and normal--to offer a frame of reference,
3) to have the day care children play and use equipment new to them at the center, and
4) to allow the providers the luxury of sitting and observing and concentrating fully on center children involved in activities. This field trip was a follow-up to a group meeting emphasizing child development observation skills.

The final trip for session I was a day at the zoo. This resource received the most provider votes as the choice of where they would like to go but had not been able to go. This trip became a logistic hurdle because several providers wanted to bring grandchildren or other relatives in addition to their day care children. We ended up on a 95° day in July with fourteen providers and thirty-nine children--staff were in, around and between that number! Each provider brought a picnic lunch for her own children and the project supplied beverage and ice cream.

The purpose for this adventure was:

1) an opportunity, at session end, for all providers to meet each other's day care children, and
2) it was like the staff gift to the providers and,
3) it was an experience we were sure would be remembered kindly long after the session ended.

In retrospect, the most enjoyable part of the zoo day for providers seemed to be the picnic lunch. Everyone could sit down, enjoy good food and company and not worry about the crumbs. For staff, it was a BUSY day, checking that everyone arrived, that children didn't get lost, escorting groups to the rest rooms, pushing baby carts, taking pictures--to name a few. By mutual staff decision, we voted not to offer the opportunity to session II providers who were double the number of session I.

SESSION II

As staff evaluated the probable lasting effects of the several field trips in session I, we agreed that the library experience and obtaining a card was probably the area on which we should concentrate. We also acknowledged that more follow-through should be planned in connection with the visit. Therefore, a Library Book List Form was given to each provider and she was asked to keep a record of all books checked out from the library. A further improvement was that the library trip was scheduled earlier in the session to allow the providers time to return to the library without project staff. During the home visits, providers were reminced and encouraged to use library facilities.

In addition to the field trips in which providers and children actually experienced community resources, we gave providers several helpful handouts.

SESSION I - HANDOUTS

During session I we were visiting providers in six separate neighborhoods of the city. The trainers assembled a community resource sheet for each of these communities which included: parks, recreation center (program schedule), library (open days and times) and bus numbers which served these resources. The intent of this handout was two-fold, it was a helpful description of services for providers and, of necessity, the trainers had to discover more about each community visited as they spoke with personnel at the various resources. In this way, we were better prepared to share information with providers because we experienced it first hand.

SESSION II

As a new session began and we counted eleven neighborhoods now being served, we felt that too much staff time would be spent collecting the raw information and then condensing it into a short, readable form. A little exploring turned up two resources already in print, in ample quantity and, they were free. One was a booklet, "Community Communique", edited in the City Manager's office. We distributed that during a home visit. The other was, of all things, the yellow pages of the telephone book, the civic section. It was enjoyable for staff and providers together to become better acquainted with a resource all of us use regularly.

2.8 HOME VISITS

In both sessions of the Orientation, home visits were scheduled to run approximately one to one and one-half hours in length. On the initial home visit each provider was asked what was the best weekday and time for her home visits, and trainers made every effort to comply with the requests. It had been determined by staff that home visits would be made on Tuesdays, Wednesdays, and Thursdays allowing Monday and Friday for office conferences, reports and organization of materials. Home visit schedules were thus based on proximity of providers' homes and their stated desire as to time and day. Another consideration was arranging a time when day care children would be present and awake. The emphasis on all home visits was child involvement and participation as well as the individualization of the presentation geared to each provider and her particular needs, concerns and situation.

SESSION I

In session I initial "get acquainted" visits were made to approximately thirteen providers. No paper work was done on these visits. The purpose was for staff and provider to meet and talk with each other, to establish communication. In addition, the majority of providers were visited simultaneously by two staff members so that the providers would have met both and would be comfortable with either. In retrospect, the providers who had verbally agreed (during the telephone call from 4C) to enroll in the program did not need this extra attention and staff time could have been used more efficiently. Staff initially underestimated the strength and interest of providers. It was later determined that the assessment questionnaire could be completed on the initial visit and only [illegible] need be introduced to the provider.

Home visits were made on a weekly basis and were approximately one hour in length. Providers were visited by the same trainer throughout the session. At the beginning of the hour, a dialogue took place between provider and trainer about the week's subject matter. This was followed by child participation in the week's activity. Although the handout materials were identical for each provider, the presentation was individualized to the particular provider and her children.

Because of the small number of providers involved (twenty) and their limited geographic area, it was possible in session I to substitute three field trips for three home visits. The last home visit was set aside for a final evaluation and assessment of the orientation by the providers and to allow any "separation anxiety" to be ventilated and dealt with.

SESSION II

Due to time limitations and the increased enrollment, the "Original Questionnaire for Providers" was completed on the first home visit. Providers were visited by one trainer who was not necessarily the trainer who would be visiting them on a regular basis. However, before the second visit, staff had divided the providers according to geographic areas and a regular visiting schedule was established.

In session II, the primary focus of the home visit continued to be an emphasis on child participation and individualization of presentation. In addition, staff was concerned about the lack of follow-up on home visit topics during session I and, therefore, in session II, allotted time on each visit to review materials from the previous week's home visit and group meeting.

A great deal had been learned from session I home visits and certain new considerations were added to session II visits. Home visits were again made on a weekly basis at a mutually acceptable time for provider and trainer. Staff made a point of calling each provider before leaving for her home in order to confirm appointments and if several visits were to be made, in a row, the trainer called from a provider's home to confirm her next appointment. The importance of not missing visits and the provider's responsibility to call the trainer if an appointment could not be kept was emphasized. This was an important issue for session II in that we were dealing with a larger group of providers and a much greater geographic area than in session I.

A staff decision was made that providers would be seen weekly by the same trainer as this had seemed to work successfully in session I. The length of the home visit and general format was not changed. Due to the large number of providers involved and the wide geographic area covered, only one field trip was scheduled in session II (to the library). The final home visit was again set aside for evaluation and assessment of the orientation by the providers.

2.9 GROUP MEETINGS

SESSION I

In the original proposal, only four group meetings were scheduled. However, feedback from the "Original Questionnaire to Providers" demonstrated a strong desire to meet soon with other providers and discuss numerous subjects. We therefore scheduled eight group meetings. These were described as a night out for the provider herself and bringing along children was not encouraged unless the provider could not otherwise attend. Attendance at these meetings was not required which led to only average participation by providers. At the first meeting, four of the twenty providers were present. Our largest number at a meeting was fourteen.

During the first home visit providers were asked which evening would be best for them for a group meeting. On the basis of their answers, the evening for the group meeting was chosen. The group meetings were scheduled for approximately two to two and one-half hours. The program was arranged with a half hour social time at the beginning. Then the topic of the evening was presented for about one hour, followed by another socializing period.

The topics discussed at meetings were chosen by the providers, (see Appendix C for Topic Schedule) and outside speakers were used to cover areas where staff lacked sufficient knowledge. A consultant, unaffiliated with the project, attended session I group meetings to observe and record specific provider participation and interaction among providers. While this concept was good, we found that eight meetings was too short a period for significant change to be documented. Also, few of the same providers attended each meeting ; continuity of individual provider participation in the group was almost impossible. This procedure might be useful for training over a several month period.

SESSION II

The number of group meetings and length of meetings remained the same in session II. The topics also were the same but a greater effort was made to coordinate the group meeting topic with the home visit topic and to have follow-up from one group meeting to the next.

Transportation was offered to the first group meeting, but after that, it was expected that providers would link up with other providers in their neighborhood and use public transportation or cars to come to the meetings on their own. It was not feasible for staff to provide transportation to approximately thirty providers scattered across such a large area of the city.

A child care service was offered during session II group meetings in order to remove that barrier to provider participation. The service was located at the same facility as the meeting. Each week's activity for the children directly related to the activity demonstrated in the provider's home that week and every week a different nutritious snack was served.

Because it had been made clear to the providers that attendance at six of the eight group meetings was mandatory in order to receive their stipend, participation was far better at session II group meetings. None of the thirty-one providers (core group which remained after dropouts from the original 43) missed more than two meetings except in one case of illness which required hospitalization. After the first group meeting, which had limited attendance, a letter was sent to providers reminding them of their contractual agreement to attend six group meetings. After receipt of that letter, there was no further problem about provider attendance.

2.10 SITE OF GROUP MEETINGS

A great deal of discussion went on among staff concerning the site of the group meetings for both session I and session II. A basic premise was that the site should be a facility easily accessible by public transportation.

SESSION I

Since providers covered a relatively small geographic area and the majority of providers lived in two adjacent areas, it was decided that a neighborhood facility would be most convenient and would help to emphasize

the importance of the use of community resources within the providers' own neighborhoods. Churches were considered, but due to the varied religious affiliation of providers, that idea was rejected. In the end, a neighborhood community center was chosen as the site of session I group meetings.

SESSION II

Weather became a factor in our choice of a site for session II. During our last group meetings in session I, the extreme heat had made everyone very uncomfortable and staff decided to choose an air conditioned facility for session II.

Since session II providers covered a wide geographic area, some thought was given to holding three group meetings simultaneously, each led by one of the staff. The sites would be in three different neighborhoods where there were clusters of providers. This idea was finally discarded because the time and logistics of organizing three group meetings per week would be overwhelming for staff. Further, it would not allow for all providers in session II to have the opportunity to meet each other.

The final decision was to have one group meeting per week at the Community Chest Building where the 4C office was located. Although this meant that providers had to come to "us" instead of staff going to the neighborhoods, the advantages of the location and facilities far outweighed the disadvantages.

2.11 REFRESHMENTS

Staff decided prior to the first group meeting that refreshments should be served. There was some debate as to who should bring them, providers or staff. It was ultimately decided that staff would provide punch and providers would be asked to volunteer on a rotating schedule to bring cakes or cookies. It was also agreed that the punch be non-alcoholic in order not to offend any providers who had strong feelings on that subject.

SESSION I

An assumption was made at the first group meeting that providers were to be treated as "guests" at the meeting, and this atmosphere remained throughout the session. Providers were, therefore, served punch and refreshments by staff while they generally remained seated.

An enormous amount of staff time was used to purchase paper table cloths, napkins, silverware and ingredients for the punch. At each meeting, staff members had to spend time preparing the punch and setting up the refreshment table. Meanwhile, providers took great pride in the preparation of their home-made cakes and cookies and some recipes were exchanged informally.

SESSION II

A much greater emphasis was put on provider participation at session II group meetings. Again providers were asked to bring refreshments but it was now suggested providers serve themselves both punch and cake.

In order to make better use of staff time during the meeting, the punch was prepared in advance by the Community Chest Cafeteria Supervisor. This service also provided the cups, plates and utensils necessary to serve the food. Refreshments tended to be "store-bought" as opposed to the home-made specialities in session I. Providers accepted the request to bring refreshments but seemed more prone to pick up something at the bakery than spend time preparing refreshments at home. There was very little sharing of recipes or complimenting each other on baked items as had occurred in session I.

2.12 DESCRIPTION OF THE CHILD CARE SERVICE

For the providers who needed to bring children, whether their own or day care children, we provided child care at the evening group meetings. The purpose of this service was to accomodate providers who might not otherwise be able to attend. Because our intent was to do "more than just babysitting" a stimulating environment for the children was provided.

Since we had the responsibility for child care for every meeting, our concerns were several. First, we were concerned about where the children were at all times and their safety. We requested that all providers who brought children tell them, before arriving, what their responsibility was at the child care service. The Community Chest Building was large and we didn't want the children to be lost, or harmed or cause any damage. We asked that children not leave the child care room. When a trip to the restroom was necessary, a worker accompanied them.

Continuity in program content and personnel was important. Many of the providers children were present during the weekly home visits. To be consistent, child care service activities corresponded to that week's home visit topic. Not only did this let the children perform similar activities in a different setting, but with a whole new group of people. Each week several activities were offered and the children could choose from among them.

Another concern was to have an adequate number of child care workers who were committed to coming every week. Continuity was advantageous for two reasons. First, it strengthened program continuity. Because we had the same workers every week, who were familar with the activities and children involved, we could plan together for each week. Second, as resources themselves, the workers contributed their talents and creative skills. This way, too, they were able to alternate their attention between various activities according to immediate needs.

The children attending the night sessions ranged in age from infants to adolescents. To accomodate this wide age range four workers were needed. The supervisor was the work-student assigned to the home care training project. The assistants were the two sons of another 4C staff member and a girl employed by the Community Chest. The child care supervisor explained the training/orientation program to the workers and the purpose of the particular service they would help give. It was understood that they would work together every week and attend all of the meetings.

Refreshments for the children were not taken lightly. Concerned that the children learn more about good nutrition, discussions covered the topics of food value, its content, appeal and taste. Although cookies and snacks would have been inexpensive and easy to distribute, a definite choice was made not to serve them. Instead, refreshments such as fruits or vegetables and fruit punch were served every week.

Again, the child care service was available to those providers who needed to bring children to the group meetings. The project was happy to have provided the service and the workers were enthusiastic about having offered a creative environment in which the children learned and played. (See Appendix D for Child Care Service Topics and Activities.)

2.13 PARENT RELATIONS AND PROVIDERS

We have talked about some of our successes and we felt we had many. However, the whole area of parent relations was one we did not touch on in any depth.

SESSION I

Several providers cared for children whose mothers were high school students. Providers with grandchildren of their own often had difficulty understanding this situation. They gave good care to the children but sometimes there was little conversation or exchange of information between the parent and the provider. To encourage better communication a high school counselor spoke at one of our group meetings. The counselor and her topic were able to stimulate good discussion. Then, as we always did, a one page summary was written and given to providers as a handout on the next week's home visit.

SESSION II

From the post assessment of providers and from the staff's evaluation in the turn-around week between sessions, parent relations and communication with them had been identified as a problem. We did not feel we had adequately covered the topic. Therefore, in session II, staff decided that one way to remedy the problem would be to invite parents to join us at one of the regularly scheduled provider group meetings. This we did.

The Welfare Department volunteered to mail a flyer to all parents who had day care children with the providers. This notice invited the parents to join us for the last regular group meeting at which the topic was "Parent

Relations". The response to this mailing of over thirty parents was that four actually came to the meeting--but it was a beginning.

Staff agreed to perform a skit, first showing a poor example of a provider and a parent, then re-enacting the same situation with a good example. Topics touched-on in the skit included:

Parent	Provider
· late arrival/pick up	· too much T.V.
· no breakfast	· not enough activities
· bringing a sick child	· doesn't walk a young child to school
	· inappropriate pupishment

From all reports the skit was well received, neither group felt singled out and it was very good for what it had been intended to do, namely, stimulate discussion.

The Welfare Department also, in the same mailing as the meeting notice, sent out a one page anonymous survey. The purpose was to determine 1) whether parents would be interested in a training/orientation program similar to the providers', and 2) what topics appealed to them from the "Topics Ranked" list? At project end nine parents had sent their surveys to the 4C office.

We made a start but it is painfully obvious that in the relatively short time of our sessions, (eleven weeks and nine weeks respectively), we were really just beginning to make contact with providers and any serious relationships with parents will need to wait for another program.

2.14 NUTRITION

SESSION I

Nutrition was one of the categories listed on "Topics to be Ranked", (See Appendix B). Originally, we had intended that this topic would be demonstrated at a group meeting with a follow-up discussion on the next home visit. However, as our speaker cancelled at a late date and we were unable to replace her over the 4th of July weekend, we hastily developed an idea with the Nutrition Council (a non-profit agency located in the Community Chest Building).

Our plan was to design a chart (Appendix E) on which the provider would record all food she served to the day care children for one week. This chart would then be shared with the Nutrition Council to be analyzed by a dietician. Remarks concerning the balance and appropriateness of the diet would be written and then returned, via the trainer, at a home visit. The written remarks could then be discussed with the provider.

The basic plan was sound, but we ran up against scheduling problems. Duplicate copies of the chart had not been multilithed by the time of the appropriate provider group meeting. One sample chart was described but providers did not have one in their hand which would have assisted their understanding. The charts, of necessity, were mailed to providers. However, when one chart should have been sent for each child given care, by mistake only one copy was sent per provider. The situation became a comedy of errors Before session I was completed we were able to return most of the charts back to providers with the Nutrition Council comments.

SESSION II

Undaunted by the problems encountered in session I we again used the dietary recall sheets. With better timing and planning the charts were distributed and discussed at a group meeting. By the time trainers were making home visits the following week, most providers had started to fill in the chart. This was an opportune time to answer any questions and make suggestions. This session there was time to review the Nutrition Council analysis comments with each provider during a home visit. In addition, by

way of follow-up, a one page summary sheet of all the dietary charts was prepared by the Council. This summary was duplicated and both read and distributed at a group meeting.

The presentation of the nutrition topic has been described in some detail here because it serves as an example of the positive changes which were made between session I and II. The time taken to evaluate session I, to learn from it, and then to change or adapt for session II, was very worthwhile.

2.15 CONSULTANT SPEAKERS

We were fortunate to have money budgeted for consultants. Since one of our project objectives was to give recognition to providers as a profession, it was a great benefit to be able to introduce providers to nationally known people such as Bob Bookman and June Sale. The opportunity to meet such speakers definitely raised the level of awareness of the family day care providers. They began to see that they were not only part of a local network, but a national network too.

The thought behind increasing the providers' awareness of themselves was that as they felt they had a support group to whom they could turn, they would be encouraged to provide better care to their day care children. We saw very positive effects for the providers who were able to personally meet these resource people . Good discussion of new ideas followed. (Not to mention the stimulating effect it also had on staff!) We felt that consultant money was well spent and that all benefited from the experience.

2.16 DAY CARE PROVIDER ASSOCIATION

As session I came to an end, we heard and saw definite withdrawal signs by providers. The withdrawal concern was for "what happens to us now". Providers who had only in the past few weeks begun to reach out and relate to each other now wondered what would keep them together.

Fortunately for us in Cincinnati, several events occurred which helped us find a satisfactory answer to the dilemma. As was previously mentioned, Bob Bookman from the DCCDCA conducted an all day workshop in June during session I of the orientation pilot. At the evening session, providers heard him discuss family day care associations. Some were interested in the concept.

In addition, Pat Cox moved to Cincinnati in late spring. Pat was on a national task force representing family day care and she had just resigned as President of the State of New York Family Day Care Association. Pat was tickled to discover that providers in Hamilton County were beginning to meet each other. Pat believed in the need for providers to have a strong support system.

Between the providers' interest to continue to meet, (or as our slogan from the first Recognition Dinner said "We'll Carry On") and Pat Cox's appearance at a most appropriate time, a Family Day Care Association was formed. It's first meeting was the week after session I ended. The Association is still in it's infancy yet there are several topics which have been discussed: insurance, tax deductions, a clothing exchange, the purchase of safe toys and play. Providers want to continue to acquire knowledge about child development and how to use this information. The Association could be a vehicle to offer workshops, speakers and more learning experiences.

One of the Association members from session I attended, at her own expense, the first National Family Day Care Conference sponsored by DCCDCA in Washington, D.C., in September. She returned to describe her experience during one of the regular group meetings for session II. Now, as session II has come to a close, the Association is inviting this group of providers to join them.

Pat Cox was the resource person from the orientation pilot to the Association. Because of this link, the 4C orientation program and the Association kept in regular contact with each other. Information was shared and coordinated. Providers from session II looked forward to their first Association meeting two weeks after the Recognition Dinner. We hope that each provider who participates will continue to feel part of a support group.

3 we all cherish the blossom

3.1 PROVIDER CHARACTERISTICS: INDEPENDENCE-DEPENDENCE

All providers involved in the project were certified by the HCWD Day Care Unit. As a group, they continue to be the only certified providers in the county. However, even among certified providers there were noticeable differences in provider characteristics between session I and II.

SESSION I & SESSION II

Session I providers as a group, appeared to be an older, more isolated group of individuals than those of session II. Most had no outside activities except their church. They viewed the day care children almost like their own grandchildren and had a difficult time dealing with business aspects of family day care. Four of the twenty providers drove in session I while well over half of the session II providers drove. Session I providers were inclined to be a far more dependent group than session II providers. They needed strong encouragement from the trainers to come out to meetings and they relied on their trainers for transportation rather than exploring other avenues.

Session II providers seemed to be younger, more independent, out-going and assertive. Close bonds were made between providers and trainers but these were not based on dependency. Session II providers were more mobile and somewhat less isolated. They tended to be more vocal, especially on volatile issues such as parent relations and HCWD.

3.2 MOTIVATION

Provider motivation and genuine interest in an orientation program was high in both sessions of the training. Enrollment was entirely voluntary; providers accepted the opportunity to participate.

SESSION I

The twenty providers in session I had all expressed interest in training at one time or another to their Home Finders at HCWD. Almost every one of them enrolled readily and agreed to participate in an orientation described to them only on the telephone by an unknown staff person and agency. The stipend was not initially mentioned to session I providers, and when it was finally disclosed that they would be paid for the training, not one of the providers asked the amount of the payment.

SESSION II

This session included many providers who had not specifically requested training and in some cases the mention of the stipend involved was a motivating factor in their initial enrollment. Once becoming involved however, the motivation seemed to subtly change from the necessity to fulfill a contractual agreement in order to earn the stipend, to an internal motivation to learn, share with each other and better care for the children.

3.3 RECOGNITION AND PUBLICITY FOR HOME DAY CARE PROVIDERS

One of the primary objectives of the project was to increase each provider's self-awareness and dignity concerning the value and importance of her profession. Concurrent with this was the goal to make the community aware of the presence and importance of home day care providers.

SESSION I

Midway through session I, a workshop on Family Day Care was conducted by Mr. Bob Bookman, Director of the National Family Day Care Project of the Day Care and Child Development Council of America (DCCDCA). The workshop helped raise providers' awareness of their importance and value. Cincinnati providers were given the opportunity to meet providers from Dayton, Ohio (who came to the workshop) as well as to hear about family day care from a national perspective. In addition to providers, staff from several counties in the state and a variety of social service agencies attended the workshop.

At the end of session I, tribute was given to providers through the Recognition Dinner held in their honor. Representatives from the HCWD Day Care Unit attended and gave their personal congratulations to the providers. They also delivered a congratulatory letter to providers and staff from the Director of HCWD. The culmination of session I and the Recognition Dinner was the presentation of Certificates of Training to each provider. A few days after the Dinner, a report on the dinner was written in a very personal style by a staff member, it was then typed and each provider was sent a copy.

Due to the constant lack of time, publicity tended to be one of the neglected areas of the project. An achievement in that area, however, was that one of the local newspapers carried a feature story on the providers describing the Recognition Dinner as well as the orientation program format.

SESSION II

Because a nationally known resource person had sparked providers' interest in session I, arrangements were made to repeat the success in session II. Recognition and heightened self-awareness for providers was in part accomplished through a group meeting on Family Day Care in Other Cities conducted by Ms. June Sales, Director of the Community Family Day Care Project, Pacific Oaks College. She shared some of her own experiences in California and also spoke about family day care from a national perspective.

The National Family Day Care Conference sponsored by DCCDCA in Washington, D.C.,Sept. 8-10, 1977 was attended by two staff members and one Cincinnati provider. Back in Cincinnati, at the group meeting with June Sale, this provider reported on her experiences at the conference. To publicize the provider's trip a second article was published by a local newspaper.

Acknowledgement was again given to providers through a Recognition Dinner held in their honor at the end of the session. A special tribute and a gift was presented to the eight providers who had a perfect attendance record for both home visits and group meetings. Certificates of Achievement were presented to each provider along with a program listing all of the graduates. Although no representative from HCWD was able to attend, a letter of congratulations was sent and read at the dinner. Several community figures, including a city council member, and former mayor did participate at the dinner and offer their personal congratulations to the providers.

3.4 CONTINUITY AND FOLLOW-UP

Continuity means for our purpose, the logical connection in topics between presentations at the group meetings and home visits. Follow-up was the discussion of the same topic more than once. If an issue or question was raised at one visit, was it carried over into the next visit?

SESSION I

There was a definite lack of continuity and follow-up in session I due to scheduling changes during the session and the haphazard arrival of materials, and the number of field trips interspersed between home visits. The completion of assignments was not stressed to providers and even when they were completed they were not thoroughly followed up on by trainers. Materials arrived sporadically and toward the end of the session, several unrelated materials were given out to providers at each home visit.

SESSION II

One of the strongest achievements of session II was the improvement in continuity and follow-up. A good deal of staff time was devoted to the formulation of the training schedule in order to better coordinate home visits with group meetings.

Follow-up was stressed in session II and time was allotted during both home visits and group meetings to discuss past topics. Further, at each group meeting the activity for the children attending the child care service coincided with that particular week's home visit activity.

Some specific examples of follow-up included: (1) a Library Report Form on which to record the books they had checked out. This helped providers keep track of the books they had read and it was a visible documentation of their use of the library. (2) A record loan system was established. After our home visit on music appreciation it was apparent that although most providers had record players, very few had children's records. Therefore, an improvement over session I was that in addition to the trainers taking records into the home for one regular visit, this loan system evolved. This system allowed providers to borrow records at one group meeting and return them to the next meeting. (3) An individual dietary analysis was returned to the providers after they had completed a one week charting of all the food they served to their day care children. (See Appendix E for Food Chart). The charts were distributed at a group meeting and their use was explained. At the following home visit, trainers reviewed the charts and offered assistance to providers in correctly listing the food they served. The dietary arrangement for analysis was made by 4C with the Nutrition Council. The analysis included many helpful suggestions for providers.

3.5 DOCUMENTATION AND REPORTS

SESSION I

Each provider had a file in the Home Care Office including the "Original Questionnaire to Providers" plus their ranking of "Suggested Training Topics". Following each home visit, a Home Visit Report was completed by the trainer and these were included in the provider's file.

Group Meeting Reports were made after each group meeting. The hours that each provider participated in home visits and group meetings was also documented. At the end of each week, trainers completed a "Trainer's Weekly Report" which was reviewed by the Project Coordinator so that she could keep abreast of the situation with providers. As she herself was not personally visiting each provider these reports gave her a clear overview of how the home visits were progressing.

SESSION II

In addition to the reporting forms used in session I, charts were used in the office to document weekly home visits and attendance at group meetings for each provider. Each trainer was responsible for recording on the chart her weekly home visits. One trainer was assigned to chart group meeting attendance. That trainer was also responsible for the "Group Meeting Report" which she completed during the meeting in order to assure the most precise information.

3.6 SCHEDULING OF PROJECT TIME

We have learned the hard way, from experience, that the scheduling of time for major components of a program is fundamental to project smoothness and success. Using our clear hindsight, it now is obvious that good scheduling of time should be anticipated and written initially, into the project proposal. The problems all of us face in the original proposal of a pilot program is that the length of time needed for various components is difficult to estimate. Human nature tells us that few of us are at our best creative selves when pressured by time.

Considering the scheduling of time, we believe the easiest to estimate is probably the direct service given to providers. The length of a home visit or a group meeting is relatively stable. Driving time between visits may be a little more difficult to estimate but with care in choosing the geographic location of providers, this factor can be somewhat controlled.

The real obstacle to planned scheduling is therefore not the provider, but the staff and the myriad tasks involved in their job which are not direct service. We would now suggest that several office tasks could be examined in some detail. Considering individual categories rather than just lumping together the time for "office" would probably result in a more realistic scheduling of time needed. These are a few of the categories one might wish to consider:

1 - weekly record keeping on:
home visits/group meetings

2 - monthly tasks
what regular reporting does the funding source require?

3 - major reports of the project
quarterly, semi-annual, project end

4 - planning
for total project and week-to-week

5 - information sharing
individual conferences, staff meetings

6 - publicity or use of the media

7 - new proposals to seek continued funding

8 - ordering of resource materials

9 - documentation
mileage, hours, petty cash

10 - filing

Special time-consuming projects can possibly be anticipated prior to or early in the program, for example: making a film or slide presentation, a deadline date for a proposal for future funding, a printed project report, hostessing a seminar or workshop, or presentation of your program (or attendance) at a conference. If we can anticipate a special project we can plan ahead for it.

Finally, a discovery we made, which will not happen by chance again, was the importance of scheduling group R and R time. During our five month orientation pilot, all of the special projects we have just listed above were accomplished. Each of these undertakings was in addition to our regular job of weekly home visits and group meetings. We were only able to survive at all because of two factors: (1) team work that wouldn't say "no" and (2) knowledge from the project staff that we had a definite end date and thus the pressure was finite.

But too many times during our pilot, staff pushed themselves too long. The scheduling all of us are now accutely aware of, is that if you have a big "special" over and above the job, you need to plan relaxation time to follow. A retreat day away from the office, a long lunch, whatever, but a safety valve is necessary. We suggest some group R and R time because we found this to be very supportive--it was the joint relaxation after a job well done which gave everyone the strength to go on.

3.7 EVALUATION OF PROGRAM BY PROVIDERS

A Provider Training Feedback Form (See Appendix F) was used in both sessions. One of the summary comments from session I was that providers were so appreciative for what they received that they were not very critical. In session II providers had attended group meetings much more regularly than providers in session I. The total summary is in Appendix F.

Very briefly, results indicate that the most popular home visit topics were: art, nutrition, and observation of children. The most popular group meeting topics were: child abuse and June Sales, (the consultant on family day care).

3.8 COMPARATIVE ANALYSIS OF ASSESSMENTS

The day care home providers completed the "Original Questionnaire to Providers" in the beginning of the program and a final one at the end. This final questionnaire repeated thirty of the original eighty-six questions to establish a quantitative comparison by which a qualitative assessment of changes that occurred during the training/orientation session could be measured.

Every participant who was initially enrolled in the program completed the Original Questionnaire. Likewise, every provider who finished the program completed the final questionnaire. As a result, due to dropouts, many more providers completed the original questionnaire than the final one. To compensate for this variance, the comparative analysis was only between the twenty-nine providers who completed session II from beginning to end and who had, therefore answered both the original and final questionnaires. Actually, thirty-one providers completed session II, but two providers who had been added late in session I, chose to be carried over through the full session II. Their "Original Questionnaires" had been tabulated with session I.

Although the final questionnaire was intended to measure comparative changes from the original, some responses were constant. In certain instances, this was simply due to the design of the question. Those questions which concern factual information of course, will not vary.

In other cases, the descriptive terms used in responses didn't change. But as a matter of degree, often their significance increased. For example, the answers to question seven regarding the kind of help most providers liked were often the same. The providers had similar needs before and after the program. But in many instances at the end of session II their needs were more clear and important to the providers. In addition, alternative practical methods for satisfying their needs had become more desirable and were in higher demand. However, because of the design of the questions these changes in degree were not always readily recognized. Changes did occur. The results show it.

3.9 COMPARATIVE ANALYSIS OF RESPONSES TO PRE AND POST ASSESSMENT

The comparative analysis of the original and final questionnaires assesses significant change in many of the provider's responses. A significantly greater number of providers indicated that they would like help in specific areas, question #7. More of them wanted higher pay and provider group meetings. Fewer answered that they wanted "no" help as a day care home provider.

On question #16, "What do you want to do with other adults but can't?", nearly 2/3 more of the providers answered "nothing" on the final questionnaire. The increase indicates that these providers are more mobile and less restricted in their activity with other adults.

However, according to question #17, many more providers felt that they wanted to do things with children but couldn't. Cost and transportation were two factors that could limit their activity with children.

As question #35 shows, the providers spent more money on food, toys, and other items at the end of session II than at the initial stage of the program. Also, it was important to note that all of the providers estimated their costs on the final questionnaire whereas eight providers admitted they "didn't know" their costs on the original one.

The providers were presently using more community resources, question #44. While six had originally said that they used "none", zero responded as such on the final questionnaire. The most significant increase was in library usage. Comparatively, nine more providers were presently using a library now than before the orientation session. Regarding other community resources, question #45, a greater number replied that they would like more parks and recreational facilities available to them.

The one area showing the greatest change was library card ownership. Of the program's participants, 50% more had library cards now than did when the session started. In addition, more providers were aware of the location of their nearest library. It should likewise be noted here that several of the providers had never been to a library before participating in this training. Also as a result of the training, more providers had books for

day care children in their homes, question #49, and the condition of these books was better than what they had had prior to the program.

There were many changes in the area of safety. The providers responses showed that they were now aware of the proper medical procedure to follow if a child was cut, question #73, or burned, question #74. Originally they used a variety of remedies, but now water was used most frequently. Also, as a precautionary measure, more providers now kept emergency phone numbers near the telephone, question #75.

Just as they had responded on the "Original Questionnaire", again on the final questionnaire all twenty-nine providers answered that they had time to play with the children, question #79. But on the final questionnaire their responses were more specific. Where as none of the providers played "ball" with the children before, six providers now did. Likewise, twelve providers recorded reading and writing, dance and exercise, or singing on the final questionnaire but no one had marked these activities on the original questionnaire.

3.10 THE BLOSSOM

The comparative analysis describes a tangible picture of our program - but our pilot was more than facts, it was people and feelings too. The next two contributions were shared with session II providers at the final group meeting - the Recognition Dinner.

County of Hamilton

BOARD OF COMMISSIONERS
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ADMINISTRATOR
ANGELA GEYSEL
CLERK

OFFICE OF
HAMILTON COUNTY WELFARE DEPARTMENT
628 SYCAMORE STREET
632-6111
CINCINNATI, OHIO 45202

SETH P. STAPLES
Director

September 29, 1977

Dear Betty Coats:

Tonight's recognition dinner for the Hamilton County Welfare Department day care home providers marks the realization of an idea that started several years ago. That idea was to offer a training program for day care providers so they could share knowledge, acquire new skills, and recognize themselves as "more than just babysitters."

All of you here tonight know that since day care is becoming more visible, the public is becoming more aware of it as a professional service. It is a service that is as good as the individual who provides the care. You each know that a day care provider has to be all things to all people - the cook who knows how to fix hamburgers 101 different ways; the teacher who helps the child learn affection, patience, and understanding; the manager who runs a small home based business; and the list could go on and on.

Your successful completion of the 4C orientation program is important to you as individuals, to the children you care for, and the parents who depend on you.

It indicates your belief in the importance of quality child care.

Congratulations to you and to the 4C's Home Care Staff.

Sincerely

Sandy Smoot
Day Care Unit Supervisor

Linda Hill
Day Care Line Supervisor

Mary Stephens
Day Care Line Supervisor

CC: 4C's Home Care Staff

THE SPIRIT OF '77

In the spring of '77, a new program came on the scene.
It required a new approach, it required a work-together team.
The new program was Family Day Care by name
And it has been shaped and formed into nothing else the same.

First there was only one, then there were two or three
So as you can plainly see, it grew from "I" to "We".
It started in low, then it started to grow
But as it was growing it started to glow
And that little glow said, "We'll carry on".

The program was created like a patchwork, it was created like a poem.
We have tried to be responsive to the subtle colorings and flavor which
each provider has given in her home.
We have tried to develop understanding,
We have tried to develop trust.
Because as we were accepted into homes, we overlooked the fuss or the dust
(After all, we have it in our own!)

It has not occurred in a week or two, it has not occurred in a wink
But slowly, gradually, carefully, we are building a binding link.
Our symbol has become a smile and a red notebook, don't let it out of your hand
For hopefully, our spirit will spread across the land
And parents, providers and children, United will they stand.

Heaven knows we have had our troubles, our anger and our pain,
But those are just the birth pangs, we are fortunate they have been tame.
Now there is a challenge, as the program has evolved,
For each of us to press on, to contribute, to stay involved.

60 providers now have heightened community awareness,
they are ready to reach out.
We have opened a door for them, do they now feel strength or doubt?

Because we are responsive to human beings, because we do care,
We cannot sit or falter, we must keep climbing the stair.
There is a spirit which is special, there is a spirit which is rare.
And that spirit <u>demands</u> we go forward, that spirit says "We'll carry on."

4 appendix

Original Questionnaire to Day Care Providers

Name _____ Date _____

Provider Information:

1. How many children are in your family or have you raised?____
2. For HCWD have you ever cared for infants, 18 mos.-3 yrs., 3 - 5 yrs., over 5?
3. How long have you been a provider for HCWD? _____
4. Why did you decide to be a provider? _____
5. What do you like most about providing child care?_____
6. What do you like least about providing child care?_____
7. What kind of help would you most like in your job as d.c.h. provider? _____
8. How often do you go outside house (apt.) with child? (daily, several times week, weekly) _____
9. Where do you go with the children? Yard, park, store, neighbors _____
10. If you need any kind of assistance during the day, whom do you call, contact? (neighbor, relative, friend)_____
11. If you have to go out during the day, what do you do with the children? Friend/neighbor, take with _____
12. How do you travel? Walk, bus, car _____

12a. Do you have a current driver's license?_____

13. How often do you get together/visit another adult during a day-care day - (daily, several times week, weekly?)_____
14. How often do you get together With another adult and their children so the children can play together? (daily, several times week, weekly)_____
15. How frequently do you attend outside activities like school, church, club, etc.? (Several times week, weekly, several times month) _____
16. What do you want to do with other adults but can't?_____
17. What do you want to do with children but can't?_____
18. What topics have you been unclear about thru HCWD i.e. tax forms? _____
19. How were solutions arrived at? _____
20. Were problems reported to HCWD? _____

Placements

21. What is the average length of a placement with you? _____

22. Document frequency and length of placements _____

23. How do you handle "first day" placement problems with the children? _____

24. What do you tell the parent on the first day of the placement? _____

25. Do you have a pre-placement interview? _____

26. What is the reason for termination of placements? _____

27. Do you have liability insurance? _____

28. Do you have written permission to give prescribed medication to a child in your care? _____

Parent Information:

29. How many of the parents did you know before the child came for care? _____

30. Do you now see any of the parents at times other than when they bring/pick-up child? Yes ____ No ____

31. Does the parent tell you about what the child is like at home? Yes _____ No _____

32. Do you daily tell the parent about the child's day with you? Yes _____ No _____ Why? Why not? _____

33. What does the parent provide for the child? Formula, diapers, food _____

34. What days, hours do you care for the children? _____

35. Approximately what is the cost to you per week for the child/rens food _____, toys _____, other _____.

INFORMATION THE PARENT HAS SHARED WITH YOU, THE PROVIDER

36. Is the parent in school? _____ High School/College? What grade or year? _____ Type of training? _____ Hours of classes? _____

37. Is the parent employed? _____ Type of work done? _____ _____ Hours? _____

38. The parent comes to my house by: car, bus, walking. _____

39. What time does the child usually go to bed?_____ Wake up in the morning?_____ Is the child usually fed breakfast at home?_____

40. How many brothers and sisters does the child have?_____ Are they in day care? _____ Are there grandparents or other adults in the home?_____

41. Has the child had other day care experiences?_____ Home Provider? _____ Center? _____ What was the child's reaction? _____

42. Who regularly picks up? _____Who brings the child to your home? _____ Time of arrival? _____Time picked up? _____

43. How does the parent discipline the child at home? _____ _____

Community Resources

44. What community resources do you presently use/go to with the children (park, library, recreation center, zoo)_____

45. What resources would you like to have/go to? _____

46. Do you have a library card? _____

47. Have you ever been to a library before? _____ Are you aware of the location of nearest library? _____

48. Do day care children have library cards? _____

49. Do you have any of your own books for day care children in your home? Yes _____ No _____ Condition and appropriateness of books: appropriate: condition good, ok, torn
inappropriate: condition good, ok, torn

Eating/Feeding

50. What are three favorite foods of each child you care for? Know _____ Not Know _____

51. Name one food each child does not like. Know _____ Not Know _____

52. How many times a day do you give food to the children:
breakfast am. snack lunch pm snack dinner

53. What kinds of food do you give a child between regular meals? _____

54. What time, approximately, do you serve meals?
Regular times daily? ---------- Not regular times -----

Rest/Naptime

55. Where does each child regularly sleep? _____

56. What do do when a child won't go to sleep?_____
_____

57. About how long does each child sleep?
½ hour 1 hr. 1½ hrs. 2 hrs. 2½ hrs. 3 3½ 4 hrs.

58. What do you do while the child/ren rest? _____
_____

Training/Weaning (Infants only)

59. Who started weaning the baby from the bottle: the parents or you? _____

60. Did you wean the baby when: the parents asked you to or when you felt she/he was ready?_____

61. Did the paren.s tell you when they started or wanted to start toilet training the baby? Yes _____ No _____

62. Who started toilet training the child: the parents or you?
_____

Discipline

63. When the child under two misbehaves, what do you do? _____
_____

64. When the child two thru school age misbehaves, what do you do?
_____

Learning Materials

65. Where do you store play materials for the children?_____

66. What materials do you have for each child? Baby _____
_____ Preschooler _____
Age 5-12 _____ Over 10 _____
_____
Comment on appropriateness and condition of toys.
appropriate: condition good, o.k., broken
inappropriate: condition good, o.k., broken

67. How frequently do the children use the toys? often, seldom, never.

68. Are there newspapers and magazines in the home which can be used by the children? Yes ____ No _____

69. Can the children play in water? Indoors ___ Outdoors ___

Safety

70. When you are sick what happens to the children?_____
_____

71. Do you have written permission to give prescribed medication to child/ren in your care? _____

72. Do you have liability insurance? _____

● 73. What is the first thing you do if the child cuts himself?
_____

● 74. What do you do for a burn? _____

● 75. Where do you keep emergency numbers? _____

● 76. Who would you call in a medical emergency? First? _____
_____ Next? _____

● 77. How would you get to the hospital in a medical emergency?
_____

You The Provider

● 78. Do you have a chance to sit down and hold the child at any time during the day? _____ (If yes, when is this most likely?
_____

● 79. Do you have time to play with the child/ren? _____
(If yes, what do you usually play?) _____

● 80. Does the child regularly watch T.V.? _____
(If yes, what programs does she/he like to watch? _____
_____

81. What is the age of your own children living at home? _____
_____

82. What is your age group? _____

20-24 _____	30-34 _____	40 or over _____
25-29 _____	35-39 _____	

83. What is the last year of school you completed? _____

84. Have you received pay for any kind of work besides this home care? _____

85. What types of work/jobs have you done? _____
_____

● 86. How do you usually feel? pretty good, o.k., fair, not so good

EDITOR'S NOTE: ● indicates questions asked on the final questionnaire

SUGGESTED TRAINING TOPICS TO BE RANKED BY EACH PROVIDER

(Rank only 1,2,3, w/ others for interest)

Name _____ Date_____

Rank	Training Topics
	A. Discipline
	B. Tips on arranging the home and materials to most easily care for children
	C. How good observation skills can help us know when a child is ready to learn/accept a new challenge
	D. Activities appropriate for the age group or children I have
	E. Tips for purchase of food, equipment and materials
	F. How to use materials I have at home for children's activities
	G. How to improve my skills in talking/communicating with the parent, the Welfare Department, other service agencies
	H. Information on tax reporting, deductions and insurance
	I. How do I feel about myself/how do others feel about me?
	J. What are day care home providers doing in other areas and states outside Hamilton County?
	K. Feeding, recipes
	L. Toilet training
	M. Child Development (What to expect at different ages)
	N. Community agencies which could help me
	O. Keeping records of food expenses and equipment purchased
	P.
	Q.
	R.
	S.
	T.

Week of	Home Visit Topics	Group Meetings
July 25-29	Children's Use of Language	
Aug. 1-5	Body Movement and Exercise	
Aug. 8-12	Visit to Neighborhood Library	11 Tax Reporting for Providers
Aug. 15-19	Music Appreciation	18 Crafts and Creative Materials
Aug. 22-26	Crafts and Creative Materials	25 Family Day Care in Other Cities
Aug. 29-Sept. 2	Observation Skills	1 Child Development: Discipline and Behavior Management
Sept. 5-9	Child Development	7 Health/Safety
Sept. 12-16	Nutrition	15 Child Abuse/Neglect
Sept. 19-23	Group Outing	22 Parent Relations
Sept. 26-30	Final Assessment and Evaluation	29 Recognition Dinner

CHILD CARE SERVICE TOPICS AND ACTIVITIES

Total children served 109

Average number of children served per week was: 15

SESSION I: "Language"

Activities: name games, film strips, language skills, and word games

Refreshment: bananas

Attendance: 14 children

SESSION II: "Art and Creative Materials"

Activities: picture drawings with crayons, exhibiting individual illustrations, dance demonstration and movement exercises

Refreshment: bananas

Attendance: 15 children

SESSION III: "Music Appreciation"

Activities: music discussion, singing games, listening exercises, dance

Refreshment: plain yogurt with honey and sliced bananas

Attendance: 27 children

SESSION IV: "Water"

Activities: lesson about the water cycle, listening to water and whale calls, water-color painting and a water movie about surfing

Refreshment: watermelon

Attendance: 11 children

SESSION V: "Collage"

Activities making picture collages from various materials, a children's movie, and word games

Refreshment: granola bars

Attendance: 15 children

SESSION VI: "Food and Nutrition"

Activities: demonstration with graphics of food contents, nutrition discussion, food tasting

Refreshment: avocados, papayas and cantaloupe

Attendance: 8 children

SECTION VII: "Nature"

Activities: lesson about trees and leaves and sunlight; creating a group tree from collages, story and skit, yoga demonstration

Refreshment: raisins and apples

Attendance: 19 children

Food Served to Home Day Care Child By HCWD Provider

Child's Name: _____ Provider's Name: _____

Child's Weight: ___ Height: _____ Age: _____

Date:	Breakfast		Morning Snack		Lunch		Afternoon Snack	
	Food/Bev.	Serving Size	Food/Bev.	Serving Size	Food/Bev.	Serving Size	Food/Bev.	Serving Size
	Food/Bev.	Serving	Food/Bev.	Serving	Food/Bev.	Serving	Food/Bev.	Serving
	Food/Bev.	Serving	Food/Bev.	Serving	Food/Bev.	Serving	Food/Bev.	Serving
	Food/Bev.	Serving	Food/Bev.	Serving	Food/Bev.	Serving	Food/Bev.	Serving
	Food/Bev.	Serving	Food/Bev.	Serving	Food/Bev.	Serving	Food/Bev.	Serving

*1. - If a cereal is served, give brand name, for example: Cheerios.

*2. - If a prepared food is served give brand name, for example: Kraft Macaroni and Cheese.

*3. - Serving size should be in cups, tbs., tsp. etc.

4. - Please include everything the Child eats or drinks.

PROVIDER TRAINING FEEDBACK SHEET: SESSION II

Directions: Please rate each session in terms of the topic discussed; the presentation, and the materials given to you about the topic. Please mark with a P, F, G or E using the key below.

Key:

P = Poor G = Good
F = Fair E = Excellent

Home Visit	Topic	Presentation	Materials
1. Childrens' Use of Language			
2. Body Movement and Exercise			
3. Neighborhood Field Trip - Library			
4. Music Appreciation			
5. Arts and Creative Materials			
6. Observation Skills			
7. Child Development			
8. Nutrition			

Would you have omitted any topics? Yes No Which topics? _____

Would you have liked to discuss any other topics?
If so, what? _____

Group Meeting	Topic	Presentation	Materials
1. Tax Reporting for Day Care Providers			
2. Parent Relations			
2. Crafts and Creative Materials			
4. Child Abuse/Neglect			
5. Discipline and Behavior Management			
6. Health and Safety			
7. Family Day Care in other Cities: June Sale			
8. Parent Relations			

Would you have omitted any topics? Yes No Which topics? _____

Would you have liked to discuss any other topics? Yes No
If so, what? _____

PROVIDER TRAINING FEEDBACK SUMMARY - SESSION II

	TOPIC				PRESENTATION				MATERIALS			
Home Visit	Excellent	Good	Fair	Poor	Excellent	Good	Fair	Poor	Excellent	Good	Fair	Poor
1. Language	2	27	1	0	8	13	4	0	11	13	2	0
2. Movement	11	18	1	0	10	13	4	0	13	13	2	0
3. Library	6	17	1	1	6	14	3	2	4	14	5	2
4. Music	8	17	4	0	8	16	6	0	11	13	5	0
5. Art	17	9	2	0	11	9	5	1	16	9	3	0
6. Observation	13	12	5	0	9	15	5	0	10	13	6	0
7. Development	11	15	2	0	6	20	2	0	9	11	7	0
8. Nutrition	15	11	2	0	15	10	2	0	15	10	2	0
Group Meeting	Excellent	Good	Fair	Poor	Excellent	Good	Fair	Poor	Excellent	Good	Fair	Poor
1. Taxes	8	11	0	0	8	11	1	0	10	9	1	1
2. Public Relations	7	13	5	0	6	16	5	0	8	13	5	0
3. Crafts	14	10	2	0	13	11	4	0	15	12	1	0
4. Abuse	18	9	0	0	18	10	1	0	16	9	2	0
5. Discipline	11	16	3	0	9	14	7	0	10	16	2	0
6. Health	10	15	3	0	11	17	1	0	13	13	1	0
7. Sale	18	4	1	0	14	10	4	0	13	9	4	1
8. Relations	12	13	1	0	12	14	2	0	11	14	3	0